MARYLAND
DUALS CARE DELIVERY WORKGROUP

JUNE 29, 2016 | 1:00-4:00 PM

AGENDA

- Welcome and Introductions
- Recap of Previous Meeting
- SIM Grant Goals and Glide Path to Waiver Development and Submission
- CPC+ Update
- Review of Stakeholder Comments on Models
- Future Activity
- Public Comment

RECAP OF JUNE 1 MEETING

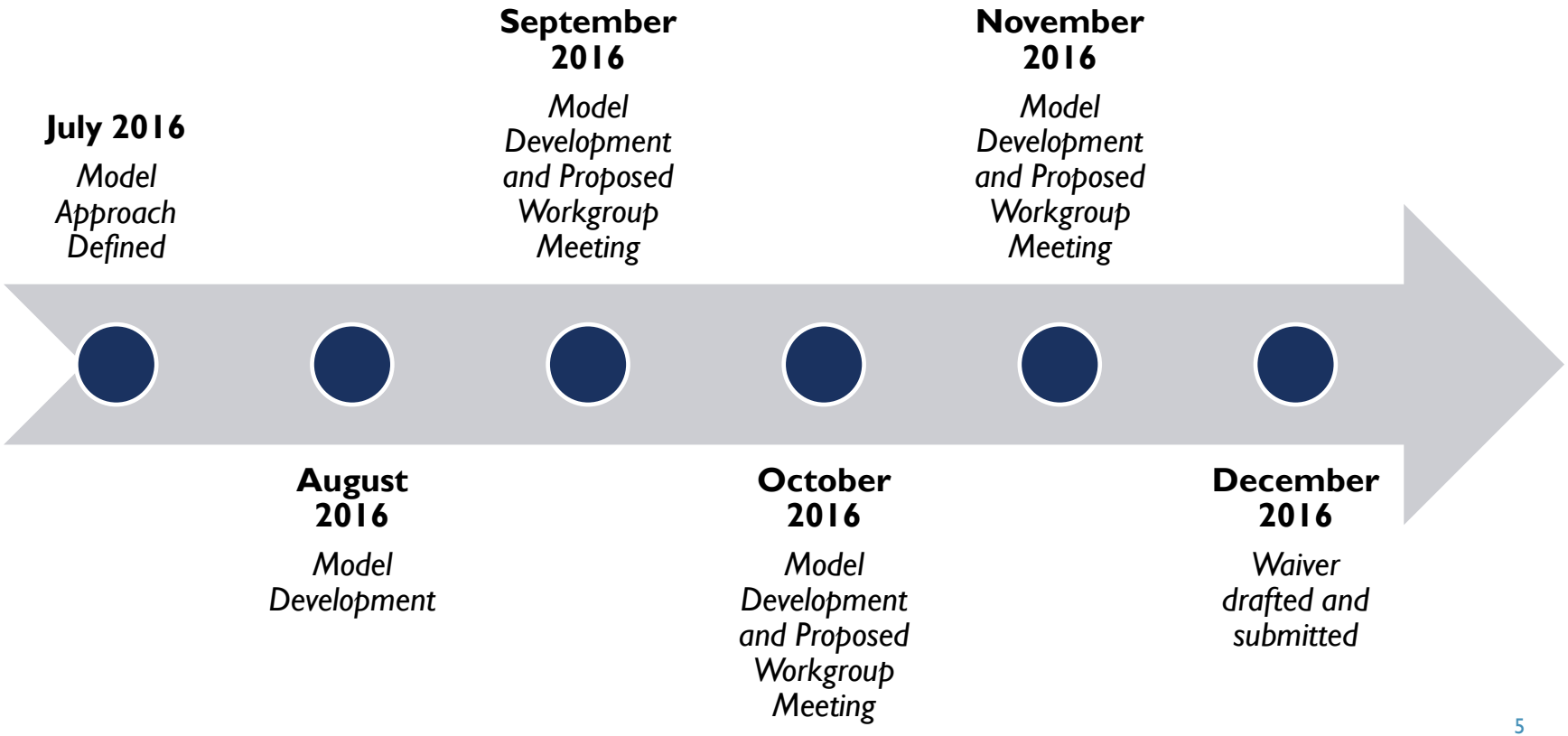
- Reviewed model options and advantages/disadvantages of the models
- Discussed possible connections between CPC+, MACRA, and duals model
- Requested formal stakeholder comments on model options to help bring closure on a single preferred approach

WHAT IS OUR GOAL?

- We want an innovation that promotes:
  - care coordination for dual eligibles,
  - that will use CRISP and feed into the HIE, and
  - that will link payment to the total cost of care for Medicaid and Medicare.
- An innovation that meets these requirements will be a success and it will offer more care coordination for duals then the population already receives
- The more integrated the system, the better

TIMETABLE

We have 6 months to complete work on a model and reach our goal. Our next phase will be focused on developing more programmatic and operational components of the model.



WORKGROUP "VOTES" ON MODEL OPTIONS

Of 25 workgroup members, 21 gave written comments on the straw models. 15 commenters took a stand on a particular model. 6 respondents do not favor any one model, but their feedback is incorporated in the themes that follow.

	MFFS	MFFS → D-ACO	D-ACO	MCO
FAVOR	**4**	**3**	**7**	**1**
Some commenters offered opinions beyond choice of a single model	2 favoring MFFS are against phasing to D-ACO, but open to risk-sharing 1 in favor as a secondary option to MCO (not counted in 4 listed above)	4 explicitly against (these are the same 4 that favor MFFS) 1 in favor as a second option to direct D-ACO (not counted in the above)	Of the 7, one suggests MCO evolving from a D-ACO model 1 suggests piloting D-ACO (not counted in the above)	1 in favor
OPPOSE	**2**	**4**	**1**	**1**
Some commenters voiced negative views on certain models	2 explicitly against	4 explicitly against (the same 4 that favor MFFS)	1 explicitly against	1 explicitly against

COMPARISON OF STRAW MODELS

Model	Advantages	Disadvantages
Managed Fee-for-Service	• Easiest for State to start up • No investment required of providers for network formation • Most flexibility for beneficiaries • **Easier access to benefits, including behavioral services**	• **Not innovative or integrated** • **Provider behavior many not change with PCMH taking accountability**
Duals ACO	• Introduces care integration and accountability for TCOC and quality • Potential MACRA benefits for physicians • **Provider-driven model** • **Innovative model for duals**	• Uncertain if today's ACOs/providers ready to step up, especially to take risk • **Longer implementation time frame** • **Existing ACOs, nationally, are not ready to take on risk**
Capitated Health Plans for Duals	• Fully shifts risk for cost, plus quality accountability, to licensed entities, giving taxpayers budget predictability and possible savings • Known design with existing provisions	• Little CMMI interest: not truly novel, not FFS • **Beneficiaries see challenges in test states** • **Lower enrollment and retention levels** • **PMPMs have been underestimated and insufficient risk adjustment** • **Mixed quality outcomes**

KEY THEMES IN STAKEHOLDER COMMENTS

1. Focus on Care Coordination
2. Beneficiary Protections and Choice
3. Pay for Value
4. Work with Existing Programs
5. Robust Data Analytics and Outcomes Reporting

1. FOCUS ON CARE COORDINATION

- MFFS and D-ACO models require comprehensive care coordination
  - Emphasis on medical, behavioral and social issues
  - Integration of care delivery: allow Community Mental Health Agencies to serve as a front-line provider to duals with SMI
- Person-centered approach with motivational interviewing strategies
- Identify a centralized coordinating entity but not a new bureaucracy
  - Support this entity with tools and resources to oversee all aspects of care
- Collaboration with an interagency team and within the interdisciplinary care team, including provider collaboration
- Ensure incentives for care coordination

2. BENEFICIARY PROTECTIONS AND CHOICE

- Open access to care and freedom of choice of providers
- Minimize administrative requirements for consumers
- Seamless linking to care
- System that links to community-based resources
- Transparency

3. PAY FOR VALUE

- Resources need to be in place to build PCMH and ACO infrastructure
- Pay up front care management fees to support providers and/or entities reduce unnecessary utilization, reduce costs, and improve quality
- Align incentives with MACRA's so clinicians can qualify for MACRA gains
- Reward providers and entities that produce desired outcomes
- Apply risk to providers
- Ensure formulas stratify risk appropriately

4. WORK WITH EXISTING PROGRAMS

- Integrate this program with current LTSS waivers and programs (e.g., health homes, CMHAs for individuals with SMI)
- Streamline care planning requirements and process across programs
- Align with hospital Global Budget Revenue (GBRs) and new All-Payer Model waiver
- Align with MACRA and other programs, on cost and quality measures
- Use infrastructure and incentives in common across programs

5. DATA ANALYTICS, OUTCOMES REPORTING

- Present information in a timely and actionable format to all key actors
- Ensure data can be entered by all individuals in the care team
- Support providers through HIE, analytic tools, and administrative simplicity
- Evaluate based on process and outcome measures that reflect enrollee experience
  - Continuously monitor program performance to be able to tweak policies and programmatic pieces that are not functioning as they should

QUESTIONS POSED BY WORKGROUP

- What is the role of managed care plans?
- Who are the care coordination entities and what is their role? And, what is the care coordination role of other entities (e.g., PCMH, D-ACO)
- How will risk be placed on providers?
- How will benchmarks be developed?
- What will be the parameters for a network, in the D-ACO model?
- How will beneficiaries be attributed?
- How will the all-payer model and hospital waivers be addressed?
- How will the program integrate with other Federal initiatives (e.g., MACRA, CPC+)?

CMMI'S INPUT SINCE LAST MEETING

- Strive to transform care delivery, not just to modify payment
  - Restructure how care is organized
  - Coordinate care across Medicare and Medicaid domains
- Leverage existing programs where possible
  - MFFS/PCMH: Look to CPC+
  - D-ACO: Build on Medicare Shared Savings Program, with waivers as needed
- Make sure duals strategy integrates with future advances to All-Payer Model
- Produce more detail of functional elements, for CMMI to socialize with other CMS units such as Center for Medicaid & CHIP Services

DEMOGRAPHIC CONSIDERATIONS

FACTS	IMPLICATIONS
80% of full-benefit duals live in Baltimore/Washington corridor	Unlikely to have sufficient lives to support D-ACO model in other places
70% of full-benefit duals were eligible first for Medicare, then for Medicaid ▪ 27% first eligible for Medicaid ▪ 2% were eligible simultaneously for both Medicare and Medicaid	Programs beneficiaries enter while Medicare-only only should serve as foundation

POSSIBLE SOLUTION: A BLENDED MODEL

Proposed adjustment based on stakeholder and CMMI comments plus facts about dual eligibles

- PCMH as common foundation
- D-ACO program for densely populated areas and MFFS in other areas
  - For D-ACO, leverage MSSP ACOs where workable
    - Willing MSSP ACO must meet criteria to serve duals set by DHMH
    - Any MSSP ACO not willing/able to coordinate with Medicaid would have duals transitioned to another qualifying ACO
  - New D-ACOs, that are not existing MSSP ACOs, could become eligible by meeting defined DHMH criteria

    CMS would waive some MSSP provisions, e.g.,
    - Provider control over governance
    - Benchmark calculation method
    - Minimum enrollment

FUTURE ACTIVITY

- July-Dec: build more detail on preferred approach; write waiver proposal
- Additional workgroup meetings:
  - July 29, 1-4 pm
  - September 20, 1-4 pm
  - October 18, 1-4 pm
  - November 15, 1-4 pm
- Next set of stakeholder meetings will get into the details of programmatic and operational components of the model
- Subgroups may be designated to give in-depth input on certain aspects of the model design (e.g., specifications of PCMH)
- DHMH and contractors will continue to work with HSCRC, CMMI, and others to flesh out concepts and coordinate with other initiatives